

This 2004 benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, including any related exclusions not contained in this benefit summary, please contact the health care service plan or health insurer and consult the individual plan's evidence of coverage. The comparative benefit summary is updated annually, or more often if necessary to be accurate. This benefit summary mirrors the Blue Cross of California PPO plan participating in the MRMIP program. This can be accessed on the DMHC website through the following link:

http://dmhc.ca.gov/coverage/mrmip/benefit_blucros.pdf

Plan Name	Plan Contact Phone Number
MEGA Life and Health Ins. Mid-West National Ins., PacifiCare Life &Health Fortis Ins. Company	1-817-255-3347 1-817-255-3102 1-866-316-9776 1-800-553-7654
Coverage summary	
Eligibility requirements	<p>You are eligible to enroll in the Post-MRMIP Graduate Product if you meet any of the following criteria:</p> <ul style="list-style-type: none"> · Apply for coverage within 63 days of the termination date of previous coverage under the MRMIP and have had continuous coverage under the MRMIP for a period of 36 consecutive months, or · Have been enrolled in a post-MRMIP standard benefit plan and move to an area within the state that is not in the service area of the plan or insurer you previously selected and you apply for coverage within 63 days of termination of previous coverage, or · Have been enrolled in a post-MRMIP standard benefit plan that is no longer available where you reside and apply for coverage within 63 days of the termination date of the previous coverage <p>· Plans may decline coverage if you are eligible for parts A and B of Medicare at the time of application and are not enrolled in Medicare solely due to end stage renal disease.</p> <p>Dependent Coverage-The following dependents may also be enrolled: Subscriber's spouse, Subscriber or spouse's unmarried children; dependent children over age 23 incapable of self-sustaining employment due to certain disabilities.</p> <p>(Consult the Plan's Evidence of Coverage for further information as availability of dependent coverage varies).</p>

When and under what circumstances benefits cease	<p>Coverage may be terminated by the Plan under the following circumstances:</p> <ul style="list-style-type: none"> · Loss of eligibility by Subscriber or enrolled dependents, including (1) Subscriber or dependent(s) move out of the Plan's service area (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) or out of California or (2) Enrolled dependents no longer meet eligibility requirements. · Termination of Plan type by Plan in which Subscriber or dependents is enrolled (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) · Non-payment of subscription charges · Fraud or material misrepresentation <p>(This list represents a general summary. Please consult the Plan's Evidence of Coverage for specific details regarding causes for termination by the Plan).</p>	
The terms under which coverage may be renewed	<p>Coverage under the Plan shall continue, except under the following circumstances:</p> <ul style="list-style-type: none"> · Loss of eligibility by Subscriber or by enrolled Dependents · Non-payment of subscription charges · Fraud or material misrepresentation · Termination of plan type by Plan in which Subscriber or dependents is enrolled (Please contact the Plan's Evidence of Coverage for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) · Subscriber moves out of the service area 	
Other coverage that may be available if benefits under the described benefit package cease	None	
The circumstances under which choice in the selection of physicians and providers is permitted	<p>This is a PPO plan. This plan allows members under all circumstances to chose the physicians and providers for all services. However if they select a non-participating physician or provider they are responsible for a larger co-payment amount and any amounts in excess of network rates. Also the co-payments they pay to non-participating providers do not accumulate toward their yearly maximum copayment limit.</p>	
Lifetime and annual maximums	\$ 200,000 annual maximum/\$ 750,000 lifetime maximum	
Deductibles	None	
Benefit Summary	Co-payments	Limitation
(*1)	\$ 2,500 per member Yearly Maximum Copayment Limit \$4,000 per family. Once you meet the yearly maximum copayment limit, BC pays 100%. No yearly maximum for Non- Participating Providers.	

Professional Services	Physician office visits, including, but not limited to preventive care, immunizations, screenings and diagnostic visits.	<p>OFFICE VISITS: For Participating Providers \$25 per office visit. For Non-Participating Providers 50% of customary and reasonable or billed charges, whichever is less and any amount in excess of customary and reasonable.</p> <p>OTHER SERVICES: 20% of the negotiated rate for other services utilizing Participating Providers. Copayment for Non-Participating Providers is 50% of customary and reasonable or billed charges, whichever is less, and any amount in excess of customary and reasonable.</p>	
Outpatient Services	Outpatient services including but not limited to, surgery and diagnostic procedures.	<p>PROFESSIONAL SERVICES: 20% of negotiated rate for Participating Providers. For Non-Participating Providers 50% of customary and reasonable or billed charges whichever is less and any amount in excess of customary and reasonable.</p> <p>HOSPITAL SERVICES: 20% of the negotiated rate for Participating Providers. Copayment for Non-Participating Providers all charges in excess of a maximum payment of \$380 per day.</p>	Limits payment to \$380 per day for Non Participating facilities. (No benefits are provided in a non-contracting hospital in California except in the case of medical emergency).

Post-MRMIP Graduate Product Comparative Benefit Matrix (AB 1401) Blue Cross -2004

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Hospitalization Services	Inpatient and Outpatient services including but not limited to, room and board and supplies.	PROFESSIONAL SERVICES: 20% of negotiated rate. For Non-Participating Providers 50% of customary and reasonable or billed charges, whichever is less and any amount in excess of customary and reasonable.	
		HOSPITAL SERVICES: 20% of negotiated rate for Participating Providers. For Non-Participating Providers all charges in excess of a maximum payment of \$650 per day for Inpatient services or \$380 per day for Outpatient services.	Payment is limited to \$650 per day for Inpatient services or \$380 per day for Outpatient services at Non Participating facilities. (No benefits are provided in a non-contracting hospital in California except in the case of medical emergency).
Emergency Health Coverage	Emergency room services at contracted and non contracted facilities for medically necessary emergencies.	HOSPITAL SERVICES: 20% of negotiated fee for Participating Providers. Co-payment for Non-Participating Providers is 20% of customary and reasonable, or billed charges, whichever is less, plus any amount in excess of customary and reasonable for the first 48 hours. After 48 hours, all charges in excess of \$650 per day**.	

Emergency Health Coverage (Cont.)		AMBULATORY SURGICAL CENTERS: 20% of negotiated fee for Participating Providers. Co-payment for Non-Participating Providers is 20% of customary and reasonable, or billed charges, whichever is less, plus any amount in excess of customary and reasonable.	
		PROFESSIONAL SERVICES: 20% of negotiated fee for Participating Providers. Co-payment for Non-Participating Providers is 20% of customary and reasonable, or billed charges, whichever is less, plus any amount in excess of customary and reasonable.	** If the member's medical condition prohibits transfer to a participating facility after 48 hours, the member's copayment will remain at 20% of customary and reasonable, or billed charges, whichever is less, plus any amount in excess of customary and reasonable until his/her medical condition permits transfer to a participating provider. Services for nonemergencies in an emergency care or urgent care setting will not be covered - 100% of all charges are payable by the member.
Ambulance Services	Emergency ambulance transport. Includes air ambulance.	20% of the negotiated fee rate for Participating Providers. For non-Participating Providers 20% of customary and reasonable or billed charges, whichever is less, and any amount in excess of customary and reasonable.	Non-emergency transportation is not covered- 100% of all charges are payable by the member unless medically necessary and pre-approved by the carrier.

Prescription Drug Benefits	Medically necessary drugs prescribed by a physician.	RETAIL PHARMACY (In California): 20% generic, 20% brand for participating Pharmacies. For Non-Participating Pharmacies member copayment is all charges except 50% of the Drug Limited Fee Schedule for generic and brand name drugs.	Limited to 30-day supply for retail.
		RETAIL PHARMACY (outside California): 20% for generic or 20% for brand plus any amount in excess of the drug limited fee schedule.	Limited to 30-day supply for retail.
		MAIL ORDER: \$10 generic, \$20 brand for Participating Mail Order Pharmacy; Mail order not available through Non-Participating Mail Order Pharmacies.	Limited to 60-day supply for mail order.
Durable Medical Equipment	Home medical equipment, including but not limited to, oxygen, parenteral and enteral nutrition, colostomy supplies, corrective prosthetics and aids, and diabetic supplies.	20% of the negotiated rate for Participating Providers. Copayment for Non-Participating Providers in 50% of customary and reasonable or billed charges, whichever is less, and any amount in excess of customary and reasonable.	Must be certified by a physician and required for care of an illness or injury.

Mental Health Services	Inpatient and outpatient mental health services, including but not limited to, mental health parity services (**2) for serious mental disorders and severe emotional disturbances for children.	INPATIENT: For Participating Providers, 20% of negotiated fee rate. For Non-Participating Providers, member pays all charges, except for \$175 per day.	Inpatient and outpatient services for Severe Mental Illness (SMI) and Serious Emotional Disturbances (SED) of a child are not limited as to day and visit maximums. Benefits are provided the same as for other medical conditions. Inpatient services limited to 10 days each calendar year Participating and Non-Participating Providers combined. Member responsible for all costs for visits over 10 days for inpatient services
		OUTPATIENT: For Participating Providers, 20% of negotiated rate. For NonParticipating Providers, the members pays 50% of customary and reasonable charges or billed charges, whichever is less, plus any charges in excess of customary and reasonable.	Inpatient and outpatient services for Severe Mental Illness (SMI) and Serious Emotional Disturbances (SED) of a child are not limited as to day and visit maximums. Benefits are provided the same as for other medical conditions. Out-patient service limited to 15 visits each calendar year Participating and Non-Participating Providers combined. Member responsible for all costs over 15 visits for outpatient services.
Residential treatment	Transitional residential recovery services.	Not a covered benefit	Not a covered benefit
Chemical Dependence Services	Substance abuse treatment or rehabilitation		No benefits will be provided for chemical dependency, substance abuse, alcoholism, or drug addiction.
	Inpatient Alcohol and Drug Abuse Detoxification	20% of negotiated fee rate for Participating Providers. For Non Participating Providers. 20% of customary and reasonable or billed charges whichever is less, and any amount in excess of customary and reasonable.	Inpatient Alcohol and Substance Abuse Detoxification is covered on an inpatient basis only, when medically necessary and subject to Prior Authorization. Benefits limited to removal of toxic substances. Outpatient not a covered benefit.

Home Health Service	Home health services through a home health agency	20% of negotiated fee rate for Participating Provider for Non-participating Providers. 50% of customary and reasonable or billed charges, whichever is less, and any amount in excess of customary and reasonable.	Services require Prior Authorization.
	Home health and hospice care services (***)		
Custodial care and skilled nursing facilities	Skilled nursing care and skilled nursing facilities services.	Not Covered unless carrier recommends as a medically appropriate more cost effective alternative plan of treatment. For Participating Providers, 20% of Negotiated Fee Rate. For Non-Participating Providers 50% of customary and reasonable or billed charges, whichever is less and any amount in excess of customary and reasonable, is the responsibility of the member. Custodial Care is not covered.	

(**1) Percentage co-payments represent a percentage of actual cost. In a PPO, percentage co-payments for services provided by non-participating providers are a percentage of usual, customary or reasonable rates or billed charges, whichever is less, and enrollees are also responsible for any excess amount.

(**2) Health Plans in California are required by law to provide certain mental health services according to the same terms and conditions as other similar medical benefits. Please contact the individual plan for

(**3) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.